



Statement of Financial Policy for Professional Services

Welcome to our practice. We hope to make your visits with us as pleasant as possible. Aside from the emotional and physical component of any treatment, there is often a degree of financial consideration as well. Reviewing our Financial Policy at this time greatly helps avoid any possible future misunderstanding(s).

1. Our relationship and our contract is with you. **We do not provide dental services to your insurance company, and have no responsibility to the insurance company. We will not compromise your dental care to satisfy insurance company recommendations.** Initials _____
2. **As a courtesy**, we will file your claims with your **primary insurance** policy. If you have a second insurance, once you have received a response from your primary insurance company you should then send a copy of this response to your second insurance they will pay you directly. Initials _____
3. Often insurance companies will use the term “**Usual and Customary**”, or similar language when denying charges for dental care. **The implication is that the Doctor charges are more than is reasonable** for a given procedure. Universal “Usual and Customary” fee schedules **do not exist!** The amount an insurance company reimburses for a procedure will vary with the company, the type and quality of the policy, the zip codes where charges were made and sometimes even the age or health of the patient. Initials _____
4. **CANCELLATION POLICY:** Similar to other industries with a finite amount and no option to recover lost revenue for missed appointments, we require you to inform our office of a cancellation or rescheduling of any appointments at least 1 (one) business day before the appointment (Monday 9 am appt. needs to be cancelled before 9 am the Friday before.) Due to the nature of dentistry and the advance planning of treatment, such notice is mandatory. Shorter notices prevent us from efficiently operating our practice and unfairly prevent other patients from receiving needed care. Our facilities operate on a fixed schedule and limit the total time available to treat our patients. Without this 24 hour advanced notice, you may be charged \$100.00 (one hundred dollars). **Initials** _____
5. The patient understands and agrees that he/she is responsible for all amounts due and further agrees to pay any fees (including attorney’s fees and other costs) associated with the collections as well as interest in the amount of 1/5% per month on amounts due more than 90 days. After 120 days past due we turn all accounts over to an outside debt collection service which may negatively impact your credit score. Initials _____

We are all too aware of the current nationwide crisis in healthcare financing. Quality, personalized dental care is sometimes, of necessity, quite expensive. Despite the pressure to pass along increased costs to the patient, we work hard on your behalf to contain fees and other charges. We are here to serve you for your dental needs. If we have done well, please tell your family and friends. If we have not, please tell us! **I have read and understand the above. I understand that I may receive a copy of this form upon request.**

Patient Signature: _____ **Print Name:** _____ **Date:** _____

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